# MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

#### GENERAL INFORMATION

# **Requestor Name and Address**

MEMORIAL HERMANN HOSPITAL SYSTEM 3200 SOUTHWEST FRWY SUITE 2200 HOUSTON TX 77027

### **Respondent Name**

ACIG INSURANCE CO

# **Carrier's Austin Representative Box**

Box Number 47

### **MFDR Tracking Number**

M4-07-0561-01

#### REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Due to the nature of the patient's injuries, he required emergency services and supplies during his stay, including surgical interventions. The hospital billed its usual and customary charges in the total amount of \$109,776.00. Due to the unusually extensive services and supplies provided for the patient's care and treatment, the hospital's usual and customary charges for room and board, ancillary services and supplies and drug charges should be paid at a fair and reasonable rate. Requestor submits that a fair and reasonable rate for treatment of this injured employee is the usual and customary charges incurred since the carrier refused to conduct an audit to refute those charges. Requestor is owed an additional \$43,892.10, plus interest."

**Amount in Dispute: \$43,892.10** 

## RESPONDENT'S POSITION SUMMARY

<u>Respondent's Position Summary</u>: The respondent did not submit a response to this request for medical fee dispute resolution.

Response Submitted by: None

## **SUMMARY OF FINDINGS**

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
October 3, 2005 through October 13, 2005	Inpatient Surgery	\$43,892.10	\$0.00

#### FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

#### **Background**

- 1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
- 2. 28 Texas Administrative Code §134.401(c)(5)(A), effective August 1, 1997, 22 TexReg 6264, requires that when "Trauma (ICD-9 codes 800.0-959.50)" diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate.
- 3. 28 Texas Administrative Code §134.1, effective May 16, 2002, 27 TexReg 4047, requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Labor Code §413.011 until such period that specific fee guidelines are established by the commission."
- 4. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
- 5. This request for medical fee dispute resolution was received by the Division on September 28, 2006.
- 6. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated November 8, 2005

- 214-75% of reasonable & customary charge.
- B15-Procedure/service is not paid separately.
- W10-Payment based on fair & reasonable methodology.
- 500-Reimbursement amount based on U&C allowance.

Explanation of benefits dated May 31, 2006

- 168-No additional allowance recommended.
- W3-Additional payment on appeal/reconsideration.
- 506-Re-evaluated bill, payment adjusted.
- W10-Payment based on fair & reasonable methodology.
- W4-No additional payment allowed after review.

### **Findings**

- 1. This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of former Division rule at 28 TAC §134.401(c)(5)(A), which requires that when "Trauma (ICD-9 codes 800.0-959.50)" diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate. Review of box 67 on the hospital bill finds that the principle diagnosis code is listed as 820.21. The Division therefore determines that this inpatient admission shall be reimbursed at a fair and reasonable rate pursuant to Division rule at 28 Texas Administrative Code §134.1 and Texas Labor Code §413.011(d)
- 2. 28 Texas Administrative Code §133.307(g)(3)(C)(iv), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to send additional documentation relevant to the fee dispute including a statement of the disputed issue(s) that shall include "how the submitted documentation supports the requestor position for each disputed fee issue." Review of the submitted documentation finds that the requestor did not state how the submitted documentation supports the requestor's position for each disputed fee issue. The Division concludes that the requestor has not met the requirements of 28 Texas Administrative Code §133.307(g)(3)(C)(iv).
- 3. 28 Texas Administrative Code §133.307(g)(3)(D), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:
  - The requestor's position statement states that "Due to the nature of the patient's injuries, he required
    emergency services and supplies during his stay, including surgical interventions. The hospital billed its
    usual and customary charges in the total amount of \$109,776.00. Due to the unusually extensive services
    and supplies provided for the patient's care and treatment, the hospital's usual and customary charges for
    room and board, ancillary services and supplies and drug charges should be paid at a fair and reasonable

rate. Requestor submits that a fair and reasonable rate for treatment of this injured employee is the usual and customary charges incurred since the carrier refused to conduct an audit to refute those charges. Requestor is owed an additional \$43,892.10, plus interest."

- The requestor does not discuss or explain how payment of \$43,892.10 would result in a fair and reasonable reimbursement.
- The requestor did not provide documentation to demonstrate how it determined its usual and customary charges for the disputed services.
- The requestor did not submit documentation to support that the payment amount being sought is a fair and reasonable rate of reimbursement.
- The Division has previously found that a reimbursement methodology based upon payment of a hospital's billed charges, or a percentage of billed charges, does not produce an acceptable payment amount. This methodology was considered and rejected by the Division in the *Acute Care Inpatient Hospital Fee Guideline* adoption preamble which states at 22 Texas Register 6276 (July 4, 1997) that:
  - "A discount from billed charges was another method of reimbursement which was considered. Again, this method was found unacceptable because it leaves the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living. It also provides no incentive to contain medical costs, would be administratively burdensome for the Commission and system participants, and would require additional Commission resources."
- The requestor does not discuss or explain how payment of the requested amount would satisfy the requirements of Division rule at 28 TAC §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

## Conclusion

**Authorized Signature** 

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under 28 Texas Administrative Code §133.307(g)(3)(C), and §133.307(g)(3)(D). The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

## ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the services in dispute.

Signature	Medical Fee Dispute Resolution Officer	Date	
Signature	Medical Fee Dispute Resolution Manager		

# YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Texas Administrative Code §148.3(c).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.